A Practical Approach to the Family That Expects a Miracle*

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When a patient is extremely ill and/or dying, and the family expects a miraculous recovery, this situation can be very challenging to physicians, particularly when there is certainty that the miracle will occur through divine intervention. A practical approach is therefore provided to clinicians for engaging families that anticipate the miraculous healing of a sick patient. This strategy involves exploring the meaning and significance of a miracle, providing a balanced, nonargumentative response and negotiation of patient-centered compromises, while conveying respect for patient spirituality and practicing good medicine. Such an approach, tailored to the specifics of each family, can be effective in helping a family come to a place of acceptance about the impending death of their loved one. ***(CHEST 2009; 135:1643–1647)***

Abbreviation: CPR = cardiopulmonary resuscitation

The word, "miracle," comes from the Latin *miraculum*, a wonder, marvel, or wonderful thing, and the related verb *mirari*, to marvel, or to be amazed or astonished.[1,2] When patients are extremely ill and/or dying, and loved ones expect a marvelous, amazing, or astonishing recovery, this situation can be very challenging. And even more so to physicians, particularly, when there is certainty that this wonderful thing will occur through divine intervention. Outlined below is an approach to engaging families that anticipate the miraculous healing of a sick patient, particularly when spiritual or religious beliefs are the underpinnings of this expectation. The elements of this strategy, exploring the meaning and significance of a miracle, providing a balanced nonargumentative response and negotiation of patient-centered compromises while conveying respect for patient spirituality and practicing good medicine, will be illustrated by walking through a case.

Explore the Meaning and Significance of a Miracle

Mrs. Clark is a 75-year-old woman with a history of hypertension and non-insulin-requiring diabetes, who was admitted to the ICU for ventilatory support because of multilobar pneumonia and respiratory failure. Her clinical course over the last 10 days has been characterized by evolving ARDS, progressive renal failure, uncontrolled sepsis with hypotension, and unresponsiveness. It is the conclusion of the attending physician (Dr. Carr) and the medical team that the likelihood of recovery for someone her age with multisystem organ failure is very small. Therefore, they meet with her children (a daughter and two sons) to advance her level of care to comfort measures only. The family vigorously resists this suggestion, insisting that mechanical ventilation be maintained and cardiopulmonary resuscitation (CPR) be provided in the event of a cardiac arrest because, "We know a miracle will occur."

Before responding, the physician needs to determine the meaning and significance of a miracle to the family.[3] This will not only enable the physician to

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have a full sense of what the physician is "dealing with," and thus help to inform a response to the family, but it also provides an effective, nonconfrontational way of beginning the discussion. Further, when listening to the family first, the care team conveys sincerity about knowing the family's perspectives as well as a respect for their beliefs.

The expectation of miracle may reflect a belief in a divine, supernatural intervention superceding the laws of nature.[2,4,5] Most Christian faiths, and some strains of Orthodox Judaism, accept the possibility of this kind of divine action in which God acts in the present time to contravene the natural order.[6,7] In contrast, non-Orthodox Jews, many liberal Christians, and most Muslims for the most part reject this view.[6–8] For these groups, descriptions of miracles in sacred texts are symbolic and not literal; divinely mediated events may have occurred in the past, but God no longer acts in this way; and/or miracles represent divinely preordained occurrences already built into the scheme of creation by God. There is also the perspective that there is much that God does everyday without contradicting the natural order that is amazing and spectacular (*ie*, "miraculous"), which humans fail to appreciate. These are certainly generalizations, and individual adherents of a specific faith may have their own idiosyncratic views about miracles.

The expectation of divine intervention may be intensified by specific experiences and beliefs.[3] These include previous personal experiences with miracles; the sense that the current situation is a "test of faith"; and the belief that the occurrence of the miracle is dependent on unwavering or unquestioning faith. Identifying these associated beliefs may be as important as confirming that there is an expectation of divine action.

Since the expectation of a miracle may have religious implications, it is important to establish a pattern of clinical practice that conveys respect for and tolerance of the religious and spiritual beliefs of patients and their families, independent of whether there is conflict around the expectation of a miracle.[9–12] Such an approach to care may provide a measure of good will that could prove to be helpful in dealing with the family that subsequently comes to anticipate a divine intervention.

Although the language of miracles is often about divine healing, it may be an expression of at least two other things.[13] First, the family may in fact be expressing hope or optimism about the possibility of recovery, trying to maintain a positive attitude. In its most extreme form, this sense of hope may be a manifestation of denial or avoidance of the seriousness of the patient's grave situation.[14] Assuming that efforts at effective communication have been employed, clinical situations in which the anticipation of a miracle may suggest denial include the following: (1) when the family appears to lack understanding about the patient's diagnosis and prognosis; (2) when the family reaches conclusions about the patient's condition that are very different from those of the care team; and (3) when the family maintains a disproportionate optimism. Second, talk of a miracle may reflect the way in which the family expresses its anger, frustration, disappointment, and/or hurt over some aspect of care. The family may be able to seize some measure of control or even retribution, knowing that talk of a miracle can be an effective method to control the care team or even strike back at them. These two additional meanings to the term *miracle* may also be present in families that hold a belief in divinely mediated healing.

"A miracle can mean different things to different people," Dr. Carr begins. "When people say they expect a miracle, it often is about God, but sometimes it may be about hope or even frustration and disappointment. It would be very helpful to us if you could tell me what a miracle means to you?"

Provide a Balanced, Nonargumentative Response

The family clearly expresses a sincere belief in the ability of God to intervene to fully restore the health of their mother. They are certain that their faith and prayers can move God to act and more than once the experience of an uncle is cited who got better after "the doctors had said there was no hope."

The information learned from the initial discussion with the family about their meaning of a miracle can be used to frame a response. If it is discovered that the anticipation of a miracle is really an expression of hope or optimism, then it might be helpful to suggest that there are always good things, other than recovery, which are attainable, that we can also hope for. It is also helpful in these situations to patiently listen without frustration to their expressions of hope, while continuing to provide consistent information on the poor prognosis of the patient. Or, if the expectation of a miracle is instead about anger or some hurt or disrespect, efforts should be made to reestablish trust by acknowledging the emotions of the family, assuming responsibility and apologizing for any unfortunate events, and putting in place a plan for ensuring good communication and resolving any lingering issues.

However, where the expectation of miracle represents a belief in a divine intervention, little will be gained by trying to directly challenge the family about its belief. In arguing the validity of the family's

belief, the physician is only likely to alienate them.[15] Instead, an approach that is more likely to be effective is one that includes the following, which can be adapted to each family.

- Emphasize nonabandonment. One of the things that patients and their loved ones fear when death approaches is isolation and abandonment.[16] The family therefore needs to know that the care team will be attentive to the needs and comfort of the patient and that the well-being of the family will not be ignored. This is imperative especially in the setting of conflict or disagreement, where physicians may unconsciously withdraw and or distance themselves from either the patient or the family, sending a message of abandonment.
- Cite professional obligations. Just as it is important for the care team to hear the family's perspective, it also necessary for the family to appreciate the motivations and professional obligations of the caregivers.[17,18] When deciding to initiate or continue a particular treatment, the family should understand that the physician is required to determine whether the treatment is medically appropriate or effective. If appropriate or effective, would the treatment be desired by the patient under the current conditions? Or, if the patient's desires are unclear, would the treatment in question be in the patient's best interest? Thus, when death is near, there is no professional requirement that the physician will base treatment plans on the expectation of divine intervention. Rather, when death is close and inevitable, ethical and professional standards of physician conduct require that this reality not be denied or ignored, but that management should instead be focused on the patient's comfort. It is certainly very appropriate to respectfully review these professional obligations with the family.
- Reframe the meaning and manifestation of the miracle. With care about and sensitivity to the family's broader story, the physician can offer the thought that the miracle (*ie*, the amazing, the spectacular, the unbelievable) may have already occurred, or may occur in some other way.[19,20] For example, bitterly estranged family members are brought together because of the patient's illness and/or death, and, to everyone's astonishment, they are able to reconcile. The patient's death motivates a careless or wayward child to put his/her life in order, something that no one thought was possible. Or the grace and dignity with which the patient faces illness and impending death inspires surprising change in the attitude and actions of others. In other words, the amazing, astonishing, and unimaginable may occur with, because of, or after the death of the loved one. The physician might begin this conversation, by asking, "Is there anything that has already happened through all of this that has been amazing or wondrous, like a kind of miracle."
- Suggest that if a miracle is to occur, physician actions will not prevent it. Last, for those families whose worldview includes an all-powerful, sovereign God, and to the physician who is comfortable doing this, it can be suggested that if it is truly God's will that a miraculous healing occur, then there is nothing we as humans can do to prevent the healing from taking place.[19,20] Thus, as the physicians do what is expected of them, the family can go forward with the assurance that God will not allow divine will to be thwarted. This suggestion is a challenge to the family to have faith in the power of their God. Consequently, this perspective may be more skillfully and carefully presented to the family by pastoral care or clergy trusted by the family,[12] who may also be able to help the family reframe the meaning of the miracle.

In responding to the expectation of divine intervention, the goal is not to present arguments that intellectually overwhelm the family, but to provide the family with information and additional perspectives that the family can use to reshape their thinking, understanding, and experience of the current situation. To this end, exercising a little patience and allowing the family the opportunity to process what they have heard can facilitate a change in their expectations. Additionally, although the physicians may be certain of the outcome, it is also important in conversations with the family that physicians maintain a humility that allows them to acknowledge the inherent uncertainty of medicine and the occurrence of inexplicable events.

Dr. Carr continues the discussion by saying, "In responding to what you have said, I want to emphasize that my intent is not to challenge your belief in the possibility of a miracle. In fact, I have been in situations where things have occurred that have made me wonder if a miracle did occur. There are few things, however, I want to share with you, that I would like you to go home and think about and discuss among yourselves . . ." The meeting adjourns with a plan to continue the current level of care and to meet again in a day or two.

Negotiate Patient-Centered Compromises While Practicing Good Medicine

The next afternoon, the three children again meet with Dr. Carr. The previous evening they had spoken with the pastor of their church. He had indicated

that from the perspective of their faith tradition, there was no obligation to preserve life by extraordinary means when death was likely, and that it was important to "put Mom in the hands of God." The patient's two sons had accepted this, acknowledging that their mother probably would not want life-support to continue. Their sister, however, with great emotion asserts that now was not the time to "give up hope," insisting that her mother continue to receive full intensive care. The two brothers are unwilling to challenge their sister.

In many instances, simply understanding the meaning of a miracle to the family, obtained by diligent and careful conversation, will provide an effective approach for respectfully redirecting the focus of the family that is hoping for a miraculous healing. But what should be done when this approach is not successful, and family members still insist on interventions based on an expectation of a miracle? Respect and tolerance for the beliefs of the family does not mean that caregivers should acquiesce to demands for medically inappropriate or medically ineffective treatments.[12] Boundaries, albeit wide ones, do need to be set and maintained, and the care provided ultimately must be patient centered. Therapy may be nonnegotiable, such as the administration of sufficient analgesia and/or sedation to provide for the comfort of the patient. In short, while addressing the demands of the family, the physicians must continue to practice good medicine.[12,18]

However, when there is continued insistence on therapy because a miracle is anticipated, the physician should enter into further discussions with the family to identify a mutually acceptable middle ground between the demands of the family (for full intensive care and CPR) and the recommendations of the physicians (for comfort measures only). Ideally, a consensus is arrived at about the level of care in which the family does not feel marginalized, while the caregivers still have the sense of providing meaningful care. The fact that a failure to come up with a compromise will likely lead to (further) alienation between the caregivers and family members should lead to persistence in seeking some agreement. In those instances in which these types of "negotiation" discussions fail to produce a mutually agreeable outcome, the ethics committee and/or mechanisms for conflict resolution of the institution should be employed.

After additional discussion, Dr. Carr offers, "It is obvious that you are not prepared to accept our recommendation that we focus on your mother's comfort, while we do not believe it is medically appropriate to continue this level of intensive support. We need to move beyond this disagreement and come up with a compromise . . ." Following further conversation, it was agreed by everyone that, going forward, the current level of support would be maintained and not increased. However, if a new or catastrophic event occurred, including a cardiopulmonary arrest, then Mrs. Clark would be allowed to die peacefully. Three days later, Mrs. Clark became progressively bradycardic and died without the initiation of CPR.

Conclusion

The successful application of this or any other approach for redirecting the focus of a family that expects a miracle must occur against a backdrop of continuous physician efforts at establishing, encouraging, and sustaining the trust of the family. The physician does not assume that he or she should be trusted, but instead, diligently and compassionately provides the best care possible, demonstrating over time that the physician is deserving of the family's trust. Trust also thrives when the communication from the physician to the family is goal oriented and patient centered, understandable and jargon-free, truthful and honest, and timely and consistent.

There will certainly be instances in which the resolution of a conflict arising from a family's expectation of a miracle will require some kind of mediation. The ideal, however, should still be that situation in which a consensus about the direction of care is reached at the "bedside," without the intervention of "outsiders." Experience indicates that this ideal can be achieved by patiently employing an approach of genuine respect, careful listening, honest discussion, and thoughtful responses. Such a strategy, tailored to the specifics of each family, and coupled, if necessary, with persistent negotiation toward a compromise, will likely prove successful in helping the family come to a place of acceptance about the impending death of their loved one. This approach can be also be adapted and applied to other situations in which the expectations and demands of patients or their families are inconsistent with professional values or physician recommendations.

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